

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

P.O. Box 420603
San Francisco, CA 94142

NOTICE OF PROPOSED RULEMAKING

Workers' Compensation - Payments for Inpatient Hospital Services

Section 9792.1 of Title 8 of the California Code of Regulations

The Administrative Director of the Division of Workers' Compensation proposes to amend the regulations described below after considering all comments, objections and recommendations regarding the proposed action.

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Inpatient Hospital Fee Schedule ("IHFS") component of the Official Medical Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code Section 11343(a)(1) and is therefore not subject to Article 5 of the Administrative Procedure Act (commencing at Government Code Section 11346.)

This rulemaking proceeding to amend the IHFS is being conducted under the Administrative Director's rulemaking power under Labor Code Sections 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code Sections 5307.1 and 5307.4.

This Notice and the accompanying Initial Statement of Reasons are being prepared to comply with the procedural requirements of Labor Code Section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing and commenting on this non-APA rulemaking proceeding.

PROPOSED REGULATORY ACTIONS

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in the Administrative Director by Labor Code Sections 127, 133, 5307.1 and 5307.3, proposes to amend Title 8 of the California Code of Regulations, Section 9792.1. Section 9792.1 concerns fees for inpatient hospital services in workers' compensation cases.

AN IMPORTANT NOTE CONCERNING THE EFFECTIVE DATE OF THE PROPOSED REGULATIONS

In order to have these regulations take effect as soon as possible, the Division will be asking the Office of Administrative Law for the regulations to have an effective date of "effective on filing with the Secretary of State." The proposed regulations therefore have blank spaces where the effective dates will be. The Office of Administrative Law will fill in the effective date as the date on which the regulations as adopted are filed with the Secretary of State.

PUBLIC HEARINGS

Public hearings have been scheduled to permit all interested persons the opportunity to present statements or arguments, either orally or in writing, with respect to the subjects noted above, on the following dates and at the following locations:

Hearing Dates:

Southern California:

Date: Tuesday, September 26, 2000
Time: 10:00 a.m.
Place: Carmel Auditorium
State Office Bldg.
320 West 4th Street
Los Angeles, California 90013

Northern California:

Date: Thursday, September 28, 2000
Time: 10:00 a.m.
Place: Auditorium
Gov. Hiram Johnson State Office Bldg.
455 Golden Gate Avenue
San Francisco, California 94102

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation. If public comment concludes before the noon recess, no afternoon session will be held.

The Administrative Director requests, but does not require, that any persons who make oral comments at the hearing also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

AUTHORITY AND REFERENCE

The Administrative Director of the Division of Workers' Compensation is undertaking this regulatory action pursuant to the authority vested in the Administrative Director by Labor Code Sections 127, 133, 4603.5, 5307.1 and 5307.3, to modify existing regulations and to implement and make specific the provisions of Labor Code Section 5307.1.

Reference is to Labor Code Sections 4600, 4603.2, and 5307.1 and Health & Safety Code Section 1250.

INFORMATIVE DIGEST / PLAIN ENGLISH POLICY STATEMENT OVERVIEW

Labor Code Section 5307.1 requires the Administrative Director [AD] of the Division of Workers' Compensation [DWC] to "adopt and revise, no less frequently than biennially, an official medical fee schedule which shall establish reasonable maximum fees paid for medical services provided pursuant to [Division 4 of the Labor Code]." The Official Medical Fee Schedule [OMFS] was last revised effective April 1, 1999.

One portion of the OMFS applies just to hospital inpatient services. The Inpatient Hospital Fee Schedule component of the OMFS establishes a maximum "global fee" for services made in connection with particular "diagnosis related groups" [DRGs]. DRGs are codes used to group related types of procedures for reimbursement purposes.) This approach is based generally on the Medicare inpatient hospital fee setting methodology using the prospective payment system.

The maximum global fee for a specific procedure at a specific facility is determined by multiplying 1.20 by the product of the health facility's composite factor, (a factor that is based on the unique cost and service differentials applicable to specific individual facilities), and the applicable DRG weight (or revised DRG weight if a revised weight has been adopted by the Administrative Director).

1. Proposed Amendment to Section 9792.1(c)(8) - Excluding Cost Outlier Cases from the Fee Schedule

In the current IHFS, admissions where the length of stay exceeds a set threshold are excluded from the application of the fee setting methodology described above. Such admissions are referred to as “outliers.” A description of the Medicare cost outlier approach is contained in the Initial Statement of Reasons.

In 1997, Medicare dropped the use of length of stay outliers and shifted to a cost outlier methodology. A description of the Medicare cost outlier methodology is set forth in the Initial Statement of Reasons prepared for this rulemaking.

The Administrative Director has learned from both the payor and provider communities that the continued use of length of stay outliers under California’s Inpatient Hospital Fee Schedule may be causing significant shortfalls in reimbursement for some inpatient procedures where the total costs of the admission greatly exceed the fee schedule’s maximum allowable reimbursement without exceeding the length of stay outlier threshold. This situation may result in a threat to access to health care for seriously injured workers.

The proposed adoption of Section 9792.1(c)(8) will add a cost outlier methodology alongside the length of stay outlier methodology already in place. The cost outlier threshold, effective where the admission occurs on or after the effective date of the regulations, will be triggered where the total billed charges for the admission, excluding any non-medical charges such as television and telephone charges, exceed five (5) times the DRG computed reimbursement. This approach was chosen to avoid the complex hospital specific calculations required to be performed by a Medicare intermediary under Medicare’s cost outlier methodology.

2. Proposed Amendment to Section 9792.1(c)(9) - Excluding Surgically Implantable Hardware and Instrumentation from the Fee Schedule’s Maximum Computed Reimbursement

The Administrative Director has learned that the costs of the implantable hardware and instrumentation such as titanium cages used in certain spinal surgeries often exceed the total maximum global fee computed under the fee schedule.

Because of this disparity between procedure costs and fee schedule reimbursement levels, the Administrative Director has been informed that some hospitals are refusing to allow complex spinal surgeries to be scheduled in their facilities.

The proposed adoption of Section 9792.1(c)(9) will exclude the cost of implantable hardware and instrumentation for spinal surgeries, DRGs 496 through 500, from the global DRG computed fee where the admission occurs on or after the effective date of the regulations.

The cost of implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after the effective date of the regulations, will be separately reimbursed at documented cost, plus any sales tax and/or shipping and handling charges actually paid, plus 10% of documented cost.

3. Proposed Amendments to Appendix B to Section 9792.1 – Clarifying Amendments to Heading and Description Sections

The heading section to Appendix B is being amended to clarify that the outlier thresholds provided in Appendix B are length of stay outliers and to add a cross-reference to direct the regulated public to Section 9792.1(c)(8) which provides for cost outliers.

Notes are also being added to the descriptions for DRGs 496 through 500 to clarify that the cost of implantable hardware and instrumentation is excluded from the DRG computed fee and is instead reimbursed separately pursuant to § 9792.1(c)(9).

STATE REIMBURSABLE MANDATE

The Administrative Director of the Division of Workers' Compensation has determined that the proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district.

Additionally, the California Supreme Court has determined that an increase in workers' compensation benefit levels does not constitute a new State mandate for the purpose of local mandate claims because the increase does not impose unique requirements on local governments. (County of Los Angeles v. State of California, 43 Cal.3d 46 (1987)). The potential costs imposed on all public agency employers and payors by these proposed regulations, although not a benefit level increase, are similarly not a new State mandate because the regulations apply to all employers and payors, both public and private, and not uniquely to local governments.

Finally, to the extent that local governments administer hospitals seeking reimbursement under the revised inpatient fee schedule, there would be a beneficial effect - an increase in the amounts of reimbursement in certain specified cases where the implantable instrumentation exemption is invoked or the threshold value of the outlier is exceeded.

COST OR SAVINGS TO LOCAL AGENCIES, SCHOOL DISTRICTS AND STATE AGENCIES

The regulatory changes proposed would have no effect on state government as an employer, payor, or hospital administrator that would not also be felt by all other private and public sector employers, payors or hospital administrators.

The regulatory changes proposed will impose no direct or indirect costs on any local agency or school district that will require reimbursement under Part 7 (Commencing with Section 17500) of Division 4 of the Government Code.

The regulatory changes proposed will impose no nondiscretionary direct or indirect costs or savings on any local agency or school district.

To the extent that local agencies and school districts are employers who must reimburse physicians and hospitals for medical treatment of industrially injured employees, they will be subject to the same cost impacts as all other medical payors in the state. These impacts are discussed in more detail in the "Potential Economic Impact" section of this Notice.

COST OR SAVINGS IN FEDERAL FUNDING TO STATE

None. The proposed regulations will not affect any federal funding.

POTENTIAL ECONOMIC IMPACT ON BUSINESS

The Administrative Director finds that adoption of these regulations may have a significant economic impact on businesses, both adverse and beneficial.

The Administrative Director finds that adoption of these regulations will not have a significant impact on the ability of California businesses to compete with businesses in other states.

The Administrative Director has not yet considered any proposed alternatives that would lessen any adverse economic impact.

Disclosures pursuant to Government Code Section 11346.5(1)(7)(C):

The proposed regulations would most significantly affect hospitals, workers' compensation insurers, self-insured employers and workers' compensation third party administrators.

The proposed adoption of Section 9792.1(c)(8) will add a cost outlier methodology alongside the length of stay outlier methodology already in place. The cost outlier threshold, effective where the admission occurs on or after the effective date of the regulations, will be triggered where the total billed charges for the admission, excluding non-medical charges such as television and telephone charges, exceed five (5) times the DRG computed reimbursement. The effect of adopting a cost outlier methodology will be to allow the provider to be reimbursed outside of the fee schedule for reasonable and necessary charges for outlier cases.

The proposed adoption of Section 9792.1(c)(9) will exclude the cost of implantable hardware and instrumentation for spinal surgeries, DRGs 496 through 500, from the global DRG computed fee where the admission occurs on or after the effective date of the regulations. The cost of implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after the effective date of the regulations, will instead be separately reimbursed at documented cost, plus any sales tax and/or shipping and handling charges actually paid, plus 10% of documented cost.

The Division of Workers' Compensation finds that the proposed amendment of these regulations may have a significant adverse economic impact on businesses, including the ability of California businesses to compete with businesses in other states. The Division of Workers' Compensation has not considered proposed alternatives that would lessen any adverse economic impact on business and invites you to submit proposals. Submissions may include the following considerations:

- (i) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to businesses.
- (ii) Consolidation or simplification of compliance and reporting requirements for businesses.
- (iii) The use of performance standards rather than prescriptive standards.
- (iv) Exemption or partial exemption from the regulatory requirements for businesses.

COST IMPACT ON PRIVATE PERSONS AND BUSINESSES:

To the extent that private persons and entities are self-insured employers, who must themselves directly reimburse medical providers, the cost impact is the same as on self-insured governmental agencies, as discussed in the section entitled "Costs or Savings to Local Agencies, School Districts and State Agencies."

Workers' compensation insurers will also be subject to the costs and savings discussed above.

Hospitals receiving payment for services under the IHFS will, in aggregate, enjoy a beneficial economic impact to the same extent that payers will suffer an adverse impact.

A detailed fiscal analysis, dated July 28, 2000, of the fiscal impact on hospitals, payors and physicians of these proposed amendments has been prepared by the Administrative Director and is included in the rulemaking file.

ASSESSMENT OF EFFECTS ON JOB AND/OR BUSINESS CREATION, ELIMINATION OR EXPANSION

The Administrative Director has determined that the proposed regulations will not affect the creation or elimination of jobs within the State of California, the creation of new businesses or the elimination of existing jobs within the State of California, or the expansion of existing businesses within the State of California.

IMPACT ON HOUSING COSTS

The Administrative Director has determined that the proposed regulations will have no effect on housing costs.

PLAIN ENGLISH REQUIREMENTS CONCERNING SMALL BUSINESSES

The Administrative Director has determined that the proposed amendments to the regulations may affect small businesses. The express terms of the proposed action written in plain English are available from the agency contact person named in this notice. Furthermore, the "Informative Digest" above constitutes a plain English policy statement overview.

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code Section 11346.5(a)(12), the Administrative Director must determine that no alternative considered would be more effective in carrying out the purpose for which the actions are proposed or would be as effective and less burdensome to affected private persons than the proposed action.

The Administrative Director has not identified any alternatives that would lessen any adverse impact that these regulation might have on small businesses.

The Administrative Director invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

AVAILABILITY OF STATEMENT OF REASONS

An Initial Statement of Reasons has been prepared for the proposed amendments, in addition to the Informative Digest included in this Notice. The Initial Statement of Reasons will be made available for inspection at the address indicated below or a copy will be provided upon written request. Please direct all requests to the contact person identified below.

PRESENTATION OF ORAL AND/OR WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present oral and/or written statements, arguments or evidence at the public hearings.

In addition, any person may submit written comments on the proposed regulations, prior to the public hearings to:

Ms. Guia Carreon,
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

Unless submitted prior to or at the public hearings, all written comments must be received by the agency contact person, no later than 5:00 p.m. on September 28, 2000. Equal weight will be accorded to oral and written materials.

Please note: Due to the inherent risk of non-delivery, written comments should not be transmitted by facsimile.

AVAILABILITY OF TEXT OF PROPOSED REGULATIONS

The complete text of the proposed amendments will be made available for inspection or provided upon written request. Please direct all requests to the contact person identified below.

AVAILABILITY OF RULEMAKING FILE

Any interested person may inspect a copy or direct questions about the proposed regulations and any supplemental information contained in the "Rulemaking File". The rulemaking file, including all documents relied upon in this rulemaking proceeding, will be made available for inspection or provided upon written request. Please direct all requests to the contact person identified below.

CONTACT PERSON AND LOCATION WHERE DOCUMENTS MAY BE INSPECTED

Any interested person may inspect a copy or direct questions about the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file.

The rulemaking file, including the Initial Statement of Reasons, the complete text of the proposed regulations and all documents relied upon in this rulemaking may be inspected during normal business hours (8:00 a.m. to 5:00 p.m., Monday through Friday, excluding public holidays) at the following location:

Division of Workers' Compensation
455 Golden Gate Avenue, Ninth Floor
San Francisco, California 94102

Copies of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Ms. Guia Carreon
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING


If the Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly indicated will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted.

AUTOMATIC MAILING

A copy of this Notice, including the Informative Digest, will automatically be sent to those interested persons on the Administrative Director's mailing list, and to all hospitals listed by the Office of Statewide Health Planning and Development as being licensed in California during 1999.

If adopted, the regulations as amended will appear in the California Code of Regulations at Title 8, Section 9792.1.

Dated: 8/3/00



RICHARD P. GANNON
Administrative Director,
Division of Workers' Compensation

Title 8, California Code Of Regulations, §9792.1 - Payment of Inpatient Services of Health Facilities.

(a) Maximum reimbursement for inpatient medical services shall be determined by multiplying 1.20 by the product of the health facility's composite factor and the applicable DRG weight or revised DRG weight if a revised weight has been adopted by the administrative director. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a health facility for inpatient medical services not exempted under this section. However, preadmission services rendered by a health facility more than 24 hours before admission are separately reimbursable.

(b) Health facilities billing for fees under this section shall present with their bill the name and address of the facility, the facility's Medicare ID number, and the applicable DRG codes.

(c) The following are exempt from the maximum reimbursement formula set forth in subdivision (a):

- (1) Inpatient services for admissions where the length of stay exceeds the day outlier threshold established by the Health Care Financing Administration for the diagnosis-related group.
- (2) Inpatient services for the following diagnoses: Psychiatry (DRGs 424-432), Substance Abuse (DRGs 433-437), Organ Transplants (DRGs 103, 302, 480, 481, 495), Rehabilitation (DRG 462 and inpatient rehabilitation services provided in any rehabilitation center that is authorized by the Department of Health Services in accordance with Title 22, §§ 70301 - 70603 of the California Code of Regulations to provide rehabilitation services), Tracheostomies (DRGs 482, 483), and Burns (DRGs 456-460, 472, 475).
- (3) Inpatient services provided by a Level I or Level II trauma center, as defined in Title 22, California Code of Regulations sections 100260, 100261, to a patient with an immediately life threatening or urgent injury.
- (4) Inpatient services provided by a health facility for which there is no composite factor.
- (5) Inpatient services provided by a health facility located outside the State of California.
- (6) The cost of durable medical equipment provided for use at home.
- (7) Inpatient services provided by a health facility transferring an inpatient to another hospital. Maximum reimbursement for inpatient medical services of a health facility transferring an inpatient to another hospital shall be a per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under Title 8, California Code of Regulations §9792.1(a). However, the first day of

the stay in the transferring hospital shall be reimbursed at twice the per diem amount. The per diem rate is determined by dividing the maximum reimbursement as determined under Title 8, California Code of Regulations §9792.1(a) by the average length of stay for that specific DRG. However, if an admission to a health facility transferring a patient is exempt from the maximum reimbursement formula set forth in subdivision (a) because it satisfies one or more of the requirements of Title 8, California Code of Regulations §9792.1(c)(1) through (c)(5), subdivision (c)(7) shall not apply. Inpatient services provided by the hospital receiving the patient shall be reimbursed under the provisions of Title 8, California Code of Regulations §9792.1(a).

(8) Cost Outlier cases. Inpatient services for admissions on or after * _____, 2000, where the total billed charges, excluding non-medical charges such as television and telephone charges, exceed five (5) times the fee computed under subsection (a) above.

(9) Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after * _____, 2000.

Implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after * _____, 2000, shall be separately reimbursed at documented cost, plus any sales tax and/or shipping and handling charges actually paid, plus 10% of documented cost.

(d) Any health care facility that believes its composite factor was erroneously determined because of an error in tabulating data may request the Administrative Director for a re-determination of its composite factor. Such requests shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the composite factor or reaffirm the published composite factor.

(e) This section, except as provided in subsections (c)(8) and (9), shall apply to covered inpatient hospital stays for which the day of admittance is on or after April 1, 1999.

Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code.

Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

*** An important note about the effective date of the proposed amendments:**

As stated in the Notice of Proposed Rulemaking, in order to have these regulations take effect as soon as possible, the Division will be asking the Office of Administrative Law for the regulations to have an effective date of “effective on filing with the Secretary of State.” The proposed regulations therefore have blank spaces where the effective date will be. The Office of Administrative Law will fill in the effective date as the date on which the regulations as adopted are filed with the Secretary of State.

SECTION 9792.1 - APPENDIX B: DRG WEIGHTS AND REVISED DRG WEIGHTS
(California revisions shown in italics incorporate the ratios from Appendix C)

DRG Number	Description	DRG WEIGHT or <i>Revised DRG Weight</i>	<u>Length of Stay</u> Outlier Threshold <u>[Note: For Cost Outlier Cases, see § 9792.1(c)(8)]</u>	Geometric Mean LOS
1	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0907	32	7.2
2	CRANIOTOMY FOR TRAUMA AGE >17	3.0511	32	7.9
3	CRANIOTOMY AGE 0-17	1.9484	37	12.7
**4	<i>SPINAL PROCEDURES</i>	<i>1.499</i>	<i>30</i>	<i>5.5</i>
5	EXTRACRANIAL VASCULAR PROCEDURES	1.5041	26	2.9
6	CARPAL TUNNEL RELEASE	0.7582	26	2.2
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.4717	32	7.3
**8	<i>PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC</i>	<i>0.9813</i>	<i>27</i>	<i>2.2</i>
9	SPINAL DISORDERS & INJURIES	1.2646	29	5.1
10	NERVOUS SYSTEM NEOPLASMS W CC	1.2184	30	5.3
11	NERVOUS SYSTEM NEOPLASMS W/O CC	0.7879	28	3.2
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.937	29	5
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7832	29	4.7
14	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1889	30	5.1
15	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	0.7241	27	3.2
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0452	29	4.6
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6161	26	2.8
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.9399	29	4.5
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6293	27	3.2
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.5786	33	8
21	VIRAL MENINGITIS	1.4866	30	5.4
22	HYPERTENSIVE ENCEPHALOPATHY	0.8594	28	3.7

23	NONTRAUMATIC STUPOR & COMA	0.7777	28	3.3
24	SEIZURE & HEADACHE AGE >17 W CC	0.9578	28	3.9
**25	<i>SEIZURE & HEADACHE AGE >17 W/O CC</i>	<i>0.4357</i>	<i>24</i>	<i>2.8</i>
26	SEIZURE & HEADACHE AGE 0-17	0.9601	27	3.6
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.267	28	3.4
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.1707	29	4.4
**29	<i>TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC</i>	<i>0.6399</i>	<i>27</i>	<i>2.8</i>
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3295	17	2
31	CONCUSSION AGE >17 W CC	0.8369	28	3.4
**32	<i>CONCUSSION AGE >17 W/O CC</i>	<i>0.447</i>	<i>20</i>	<i>2.2</i>
33	CONCUSSION AGE 0-17	0.2071	9	1.6
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0385	29	4.2
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5941	27	3
36	RETINAL PROCEDURES	0.6265	6	1.3
37	ORBITAL PROCEDURES	0.9725	27	2.6
38	PRIMARY IRIS PROCEDURES	0.4826	17	1.9
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5406	10	1.5
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.7341	26	2.2
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3354	7	1.6
**42	<i>INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS</i>	<i>0.6051</i>	<i>13</i>	<i>1.5</i>
43	HYPHEMA	0.4119	27	2.9
44	ACUTE MAJOR EYE INFECTIONS	0.6072	29	4.3
45	NEUROLOGICAL EYE DISORDERS	0.673	22	2.9
46	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7234	28	3.7
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4623	27	2.7
48	OTHER DISORDERS OF THE EYE AGE 0-17	0.2955	27	2.9
49	MAJOR HEAD & NECK PROCEDURES	1.8074	28	3.9
50	SIALOADENECTOMY	0.8143	9	1.7
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.8367	20	1.9
52	CLEFT LIP & PALATE REPAIR	1.2768	24	2.2
53	SINUS & MASTOID PROCEDURES AGE >17	1.0682	26	2.3
54	SINUS & MASTOID PROCEDURES AGE 0-17	0.479	22	3.2
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.8366	22	2

56	RHINOPLASTY	0.883	18	2.1
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	1.0182	27	2.7
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.272	4	1.5
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.8238	26	2.3
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2072	4	1.5
61	MYRINGOTOMY W TUBE INSERTION AGE >17	1.1181	27	2.8
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2933	5	1.3
**63	<i>OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES</i>	<i>1.0892</i>	<i>27</i>	<i>3.1</i>
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1568	29	4.4
65	DYSEQUILIBRIUM	0.5177	20	2.5
66	EPISTAXIS	0.5605	21	2.8
67	EPIGLOTTITIS	0.7866	24	3.1
68	OTITIS MEDIA & URI AGE >17 W CC	0.6831	27	3.5
69	OTITIS MEDIA & URI AGE >17 W/O CC	0.516	20	2.9
70	OTITIS MEDIA & URI AGE 0-17	0.3892	15	2.7
71	LARYNGOTRACHEITIS	0.6688	27	3
72	NASAL TRAUMA & DEFORMITY	0.6364	27	2.7
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.766	28	3.4
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0- 17	0.3332	20	2.1
75	MAJOR CHEST PROCEDURES	3.1958	33	8.3
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.6427	33	8.7
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.115	28	3.5
78	PULMONARY EMBOLISM	1.4264	31	6.6
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6258	31	6.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.9121	29	4.9
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5091	30	6.1
82	RESPIRATORY NEOPLASMS	1.3329	30	5.4
83	MAJOR CHEST TRAUMA W CC	0.9716	29	4.6
84	MAJOR CHEST TRAUMA W/O CC	0.526	23	2.8
85	PLEURAL EFFUSION W CC	1.2212	30	5.3

86	PLEURAL EFFUSION W/O CC	0.6715	27	3.1
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3639	29	4.9
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9705	29	4.6
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.1006	30	5.4
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6773	24	4
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.794	27	3.7
92	INTERSTITIAL LUNG DISEASE W CC	1.1947	30	5.3
93	INTERSTITIAL LUNG DISEASE W/O CC	0.7423	28	3.7
94	PNEUMOTHORAX W CC	1.1857	29	5.1
95	PNEUMOTHORAX W/O CC	0.5974	25	3.2
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.8005	29	4.2
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5887	22	3.3
98	BRONCHITIS & ASTHMA AGE 0-17	0.6298	27	2.3
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.671	22	2.4
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5109	12	1.8
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8518	28	3.5
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5295	20	2.3
103	HEART TRANSPLANT	Excluded	Excluded	Excluded
104	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.3563	36	10.8
105	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH	5.7109	33	8.3
106	CORONARY BYPASS W CARDIAC CATH	5.5843	34	9.8
107	CORONARY BYPASS W/O CARDIAC CATH	4.0812	32	7.3
108	OTHER CARDIOTHORACIC PROCEDURES	6.1282	34	9.4
109	NO LONGER VALID	0	0	0
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1964	32	7.7
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2409	30	5.4
**112	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.6839	27	3.1
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.6579	35	9.7
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.5363	31	6.4
115	PERM PACE IMPLNT W AMI,HRT FAIL OR SHOCK OR AICD LEAD OR GEN PROC	3.5476	33	6.7
116	OTH PERM CARDIAC PACEMAKER IMPLANT OR PTCA W CORONARY ART STENT	2.5321	28	3.5

117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.195	27	2.7
118	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5889	25	2
119	VEIN LIGATION & STRIPPING	1.1997	27	3.1
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9158	29	5
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP DISCH ALIVE	1.6537	30	6
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP DISCH ALIVE	1.1446	28	3.9
123	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4695	27	2.7
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.3565	28	3.6
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	0.9738	20	2.3
126	ACUTE & SUBACUTE ENDOCARDITIS	2.4879	35	10
127	HEART FAILURE & SHOCK	1.0199	29	4.5
128	DEEP VEIN THROMBOPHLEBITIS	0.7807	27	5.6
129	CARDIAC ARREST, UNEXPLAINED	1.1414	26	1.9
130	PERIPHERAL VASCULAR DISORDERS W CC	0.941	29	5.1
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.604	28	4.1
132	ATHEROSCLEROSIS W CC	0.6749	20	2.7
133	ATHEROSCLEROSIS W/O CC	0.536	16	2.1
134	HYPERTENSION	0.576	23	2.8
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.8336	28	3.4
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5709	18	2.4
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8131	27	3.3
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7962	27	3.2
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.4982	16	2.2
**140	ANGINA PECTORIS	0.4695	20	2.6
141	SYNCOPE & COLLAPSE W CC	0.7005	27	3.1
142	SYNCOPE & COLLAPSE W/O CC	0.5231	18	2.3
**143	CHEST PAIN	0.4377	14	1.9

144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0904	28	3.9
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.6401	20	2.3
146	RECTAL RESECTION W CC	2.7356	34	9.3
147	RECTAL RESECTION W/O CC	1.5885	27	6.3
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3883	35	10.6
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5495	25	6.5
150	PERITONEAL ADHESIOLYSIS W CC	2.7109	34	9.1
151	PERITONEAL ADHESIOLYSIS W/O CC	1.2645	29	4.9
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9139	32	7.2
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1634	24	5.2
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	4.1851	36	10.8
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.335	29	3.9
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8374	30	6
157	ANAL & STOMAL PROCEDURES W CC	1.1824	28	4
158	ANAL & STOMAL PROCEDURES W/O CC	0.6272	18	2.2
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.2548	28	3.8
**160	<i>HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC</i>	<i>0.6471</i>	<i>16</i>	<i>2.3</i>
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.0573	27	3
**162	<i>INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC</i>	<i>0.5078</i>	<i>11</i>	<i>1.7</i>
163	HERNIA PROCEDURES AGE 0-17	0.866	11	3.1
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3412	32	7.5
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.227	24	4.7
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4582	29	4.3
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.8373	15	2.5
168	MOUTH PROCEDURES W CC	1.1187	27	3.2

169	MOUTH PROCEDURES W/O CC	0.6903	15	2
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.7587	33	8.1
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1146	28	3.7
172	DIGESTIVE MALIGNANCY W CC	1.2867	30	5.3
173	DIGESTIVE MALIGNANCY W/O CC	0.6744	27	2.9
174	G.I. HEMORRHAGE W CC	0.9925	28	4.1
175	G.I. HEMORRHAGE W/O CC	0.5366	17	2.7
176	COMPLICATED PEPTIC ULCER	1.1011	2	4.5
177	UNCOMPLICATED PEPTIC ULCER W CC	0.8556	28	3.8
178	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6241	19	2.8
179	INFLAMMATORY BOWEL DISEASE	1.11	30	5.2
180	G.I. OBSTRUCTION W CC	0.9153	29	4.4
181	G.I. OBSTRUCTION W/O CC	0.5204	22	3.1
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7664	28	3.5
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5496	20	2.6
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.593	27	2.7
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8424	28	3.5
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.3192	23	2.9
187	DENTAL EXTRACTIONS & RESTORATIONS	0.7049	27	3
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0727	28	4.3
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5488	27	2.5
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8786	28	3.3
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.349	36	11.1
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7057	30	5.6
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.2666	35	10.6
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.6688	31	5.9
195	CHOLECYSTECTOMY W C.D.E. W CC	2.7112	33	8.2
196	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6075	30	5.5

197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.3085	31	7.2
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1693	23	4.1
199	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3523	32	7.9
200	HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	3.021	32	7.5
201	OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES	3.4752	36	11.1
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3255	30	5.3
203	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS	1.2605	30	5.2
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2117	29	4.9
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2144	29	5
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.6543	28	3.2
207	DISORDERS OF THE BILIARY TRACT W CC	1.0507	28	4.1
208	DISORDERS OF THE BILIARY TRACT W/O CC	0.6039	21	2.4
**209	<i>MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY</i>	2.122	23	5.3
**210	<i>HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC</i>	2.1553	31	6.5
**211	<i>HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC</i>	1.2197	23	5
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.1311	35	3.9
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.6513	31	6.4
214	<i>NO LONGER VALID</i>	0	0	0
215	<i>NO LONGER VALID</i>	0	0	0
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	2.1082	32	7.4
**217	<i>WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS</i>	1.6026	34	9.2
**218	<i>LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC</i>	1.501	29	4.4

**219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	0.9324	19	2.9
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	0.58	29	5.3
221	NO LONGER VALID	0	0	0
222	NO LONGER VALID	0	0	0
**223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	0.7971	16	2.1
**224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.7557	10	1.8
**225	FOOT PROCEDURES	1.0132	27	3.1
226	SOFT TISSUE PROCEDURES W CC	1.4095	28	4.1
**227	SOFT TISSUE PROCEDURES W/O CC	0.7298	18	2.2
**228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	0.8648	26	2.3
**229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.6952	13	1.8
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.1296	27	3.3
**231	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	0.9343	27	3.1
**232	ARTHROSCOPY	0.868	27	2.5
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0329	30	5.7
**234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.9049	27	2.9
235	FRACTURES OF FEMUR	0.771	29	4.2
**236	FRACTURES OF HIP & PELVIS	0.7184	28	4.3
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.5952	27	3.2
238	OSTEOMYELITIS	1.325	32	7
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.9865	30	5.3
240	CONNECTIVE TISSUE DISORDERS W CC	1.2098	30	5.1
241	CONNECTIVE TISSUE DISORDERS W/O CC	0.5862	28	3.3
242	SEPTIC ARTHRITIS	1.0501	30	5.5
**243	MEDICAL BACK PROBLEMS	0.5447	28	4

244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7199	28	4
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.5002	27	3
246	NON-SPECIFIC ARTHROPATHIES	0.5713	28	3.3
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5587	27	2.8
248	TENDONITIS, MYOSITIS & BURSITIS	0.7428	28	3.7
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6559	27	2.7
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.6995	28	3.4
**251	<i>FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC</i>	<i>0.4071</i>	22	2.3
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.252	15	1.8
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.7265	28	3.9
**254	<i>FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC</i>	<i>0.4363</i>	25	2.8
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.2934	27	2.9
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7826	28	4
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9276	17	2.6
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7162	10	2
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8874	26	2.1
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6092	8	1.4
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.8961	12	1.8
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.782	27	2.6
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0221	34	8.9
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0773	30	5.4
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR	1.5166	29	4.6

	CELLULITIS W CC			
**266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8942	27	2.6
267	PERIANAL & PILONIDAL PROCEDURES	0.8424	27	2.7
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.009	27	2.4
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5733	30	5.9
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7061	26	2.2
271	SKIN ULCERS	1.0259	31	6
272	MAJOR SKIN DISORDERS W CC	0.995	30	5.1
273	MAJOR SKIN DISORDERS W/O CC	0.6618	28	4
274	MALIGNANT BREAST DISORDERS W CC	1.1229	29	5
275	MALIGNANT BREAST DISORDERS W/O CC	0.5882	27	2.5
276	NON-MALIGANT BREAST DISORDERS	0.6122	28	3.8
**277	CELLULITIS AGE >17 W CC	0.6583	29	5.1
**278	CELLULITIS AGE >17 W/O CC	0.4824	25	4
279	CELLULITIS AGE 0-17	0.7309	24	4.2
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.6757	28	3.4
**281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4425	24	2.5
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2551	19	2.2
283	MINOR SKIN DISORDERS W CC	0.6936	28	3.8
284	MINOR SKIN DISORDERS W/O CC	0.4371	26	2.7
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.1556	34	8.8
286	ADRENAL & PITUITARY PROCEDURES	2.2671	31	5.8
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.8727	33	8.6
288	O.R. PROCEDURES FOR OBESITY	2.0255	29	4.9
289	PARATHYROID PROCEDURES	0.9827	27	2.4
290	THYROID PROCEDURES	0.897	15	2
291	THYROGLOSSAL PROCEDURES	0.7372	8	1.7
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.5483	32	7.6
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.2297	29	3.8

294	DIABETES AGE >35	0.7546	28	4
295	DIABETES AGE 0-35	0.7359	27	3.2
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8657	29	4.3
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5188	26	3
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.4207	23	2
299	INBORN ERRORS OF METABOLISM	0.8716	28	3.9
300	ENDOCRINE DISORDERS W CC	1.081	30	5.1
301	ENDOCRINE DISORDERS W/O CC	0.5941	27	3.1
302	KIDNEY TRANSPLANT	Excluded	Excluded	Excluded
303	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.6139	32	7.8
304	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3982	31	6.9
305	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1695	28	3.4
306	PROSTATECTOMY W CC	1.2168	28	4
307	PROSTATECTOMY W/O CC	0.6455	15	2.1
308	MINOR BLADDER PROCEDURES W CC	1.512	29	4.3
309	MINOR BLADDER PROCEDURES W/O CC	0.876	18	2.1
310	TRANSURETHRAL PROCEDURES W CC	1.0248	27	3
311	TRANSURETHRAL PROCEDURES W/O CC	0.5866	11	1.7
312	URETHRAL PROCEDURES, AGE >17 W CC	0.9732	27	3.1
313	URETHRAL PROCEDURES, AGE >17 W/O CC	0.5783	13	1.8
314	URETHRAL PROCEDURES, AGE 0-17	0.4916	26	2.3
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0601	29	4.9
316	RENAL FAILURE	1.3089	29	5.1
317	ADMIT FOR RENAL DIALYSIS	0.5489	20	2
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1594	29	4.7
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.5808	24	2
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8782	29	4.7
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5838	24	3.6
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.5342	23	3.4
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.7555	24	2.5

324	URINARY STONES W/O CC	0.4298	10	1.7
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6207	27	3.1
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4188	19	2.3
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3516	27	2.3
328	URETHRAL STRICTURE AGE >17 W CC	0.6878	27	2.9
329	URETHRAL STRICTURE AGE >17 W/O CC	0.508	17	1.9
330	URETHRAL STRICTURE AGE 0-17	0.3167	9	1.6
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0009	29	4.4
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5964	27	2.7
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.8389	28	4
334	MAJOR MALE PELVIC PROCEDURES W CC	1.6359	23	4.8
335	MAJOR MALE PELVIC PROCEDURES W/O CC	1.219	17	3.7
336	TRANSURETHRAL PROSTATECTOMY W CC	0.887	24	2.9
337	TRANSURETHRAL PROSTATECTOMY W/O CC	0.6129	11	2.1
338	TESTES PROCEDURES, FOR MALIGNANCY	1.095	27	3.3
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0038	27	3.1
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2815	13	2.4
341	PENIS PROCEDURES	1.1089	21	2.2
342	CIRCUMCISION AGE >17	0.8511	27	2.9
343	CIRCUMCISION AGE 0-17	0.1529	6	1.7
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.0298	25	2.1
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	0.8552	27	2.7
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.9573	29	4.5
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.4603	25	2.2
348	BENIGN PROSTATIC HYPERTROPHY W CC	0.6958	28	3.3
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4154	20	2.1
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6797	24	3.8
351	STERILIZATION, MALE	0.2347	5	1.3
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.6263	27	2.9

353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	2.1179	31	6.4
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.4963	28	5
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	0.918	11	3.4
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.7701	12	2.5
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.4309	32	7.6
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2021	19	3.8
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8452	10	2.9
360	VAGINA, CERVIX & VULVA PROCEDURES	0.8708	17	2.7
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1872	23	2.6
362	ENDOSCOPIC TUBAL INTERRUPTION	0.3	5	1.4
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.7485	21	2.6
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.6985	27	2.5
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7085	29	4.7
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1857	29	4.9
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5309	24	2.1
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.9698	29	4.9
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.5367	27	2.5
370	CESAREAN SECTION W CC	1.0587	26	4.3
371	CESAREAN SECTION W/O CC	0.7054	11	3.3
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.559	20	2.4
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3987	7	1.7
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7625	11	2.3
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.6809	28	4.4
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4822	25	2.3
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.0517	26	2.5

378	ECTOPIC PREGNANCY	0.8126	15	2.3
379	THREATENED ABORTION	0.4028	21	2.1
380	ABORTION W/O D&C	0.3501	12	1.5
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4809	14	1.7
382	FALSE LABOR	0.2086	6	1.2
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4636	27	2.8
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.3539	22	2
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.3665	26	1.8
386	EXTREME IMMATUREITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.5063	42	17.9
387	PREMATURITY W MAJOR PROBLEMS	3.0777	37	13.3
388	PREMATURITY W/O MAJOR PROBLEMS	1.857	33	8.6
389	FULL TERM NEONATE W MAJOR PROBLEMS	1.4862	32	5.1
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3058	28	3.4
391	NORMAL NEWBORN	0.1515	11	3.1
392	SPLENECTOMY AGE >17	3.1695	33	8.1
393	SPLENECTOMY AGE 0-17	1.3386	33	9.1
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.6479	28	4.5
395	RED BLOOD CELL DISORDERS AGE >17	0.8181	28	3.6
396	RED BLOOD CELL DISORDERS AGE 0-17	0.6284	27	2.7
397	COAGULATION DISORDERS	1.2679	28	4.2
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2242	29	4.9
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6836	27	3.2
400	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6402	31	6.3
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.5653	32	8.1
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.0145	27	2.9
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6964	30	6
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.7917	28	3.3

405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.8978	29	4.9
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.6147	32	7.3
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1516	28	3.5
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.7294	29	4.7
409	RADIOTHERAPY	0.9534	29	4.3
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	0.7968	20	2.6
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.4214	16	1.8
412	HISTORY OF MALIGNANCY W ENDOSCOPY	0.5175	23	2.4
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3777	30	5.7
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7041	28	3.2
**415	<i>O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES</i>	<i>1.7256</i>	<i>35</i>	<i>10.8</i>
416	SEPTICEMIA AGE >17	1.4797	30	5.8
417	SEPTICEMIA AGE 0-17	0.7688	28	3.3
**418	<i>POSTOPERATIVE & POST-TRAUMATIC INFECTIONS</i>	<i>0.6583</i>	<i>29</i>	<i>5</i>
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8831	28	4.1
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6064	24	3.2
421	VIRAL ILLNESS AGE >17	0.7069	28	3.3
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.5347	25	2.7
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.569	30	5.8
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	Excluded	Excluded	Excluded
425	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	Excluded	Excluded	Excluded
426	DEPRESSIVE NEUROSES	Excluded	Excluded	Excluded
427	NEUROSES EXCEPT DEPRESSIVE	Excluded	Excluded	Excluded
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	Excluded	Excluded	Excluded
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	Excluded	Excluded	Excluded
430	PSYCHOSES	Excluded	Excluded	Excluded
431	CHILDHOOD MENTAL DISORDERS	Excluded	Excluded	Excluded

432	OTHER MENTAL DISORDER DIAGNOSES	Excluded	Excluded	Excluded
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	Excluded	Excluded	Excluded
434	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC	Excluded	Excluded	Excluded
435	ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC	Excluded	Excluded	Excluded
436	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	Excluded	Excluded	Excluded
437	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY	Excluded	Excluded	Excluded
438	NO LONGER VALID	0	0	0
439	SKIN GRAFTS FOR INJURIES	1.6391	30	5.4
**440	<i>WOUND DEBRIDEMENTS FOR INJURIES</i>	<i>1.4281</i>	30	6
**441	<i>HAND PROCEDURES FOR INJURIES</i>	<i>0.9218</i>	26	2.2
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.1818	30	5.4
**443	<i>OTHER O.R. PROCEDURES FOR INJURIES W/O CC</i>	<i>0.9138</i>	26	2.5
444	TRAUMATIC INJURY AGE >17 W CC	0.7007	28	3.7
**445	<i>TRAUMATIC INJURY AGE >17 W/O CC</i>	<i>0.3928</i>	25	2.6
446	TRAUMATIC INJURY AGE 0-17	0.2942	22	2.4
447	ALLERGIC REACTIONS AGE >17	0.4927	17	2
448	ALLERGIC REACTIONS AGE 0-17	0.0968	1	1
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.786	27	2.8
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.2933	13	1.7
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2613	17	2.1
452	COMPLICATIONS OF TREATMENT W CC	0.9476	28	3.7
453	COMPLICATIONS OF TREATMENT W/O CC	0.496	20	2.3
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.9035	27	3.3
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.3332	18	2
456	BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	Excluded	Excluded	Excluded
457	EXTENSIVE BURNS W/O O.R. PROCEDURE	Excluded	Excluded	Excluded
458	NON-EXTENSIVE BURNS W SKIN GRAFT	Excluded	Excluded	Excluded
459	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	Excluded	Excluded	Excluded
460	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	Excluded	Excluded	Excluded
**461	<i>O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH</i>	<i>0.932</i>	27	2.5

	<i>SERVICES</i>			
462	REHABILITATION	Excluded	Excluded	Excluded
463	SIGNS & SYMPTOMS W CC	0.6907	28	3.6
464	SIGNS & SYMPTOMS W/O CC	0.4872	24	2.7
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.5858	26	2.2
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6336	27	2.6
467	OTHER FACTORS INFLUENCING HEALTH STATUS	0.4669	26	2.3
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.6202	35	9.9
469	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0	0	0
470	UNGROUPABLE	0	0	0
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.4771	31	Excluded
472	EXTENSIVE BURNS W O.R. PROCEDURE	Excluded	Excluded	Excluded
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4853	33	7.9
474	NO LONGER VALID	0	0	0
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	Excluded	Excluded	Excluded
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2234	34	9.5
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.7461	30	5.5
478	OTHER VASCULAR PROCEDURES W CC	2.2981	30	5.2
479	OTHER VASCULAR PROCEDURES W/O CC	1.4113	27	3.2
480	LIVER TRANSPLANT	Excluded	Excluded	Excluded
481	BONE MARROW TRANSPLANT	Excluded	Excluded	Excluded
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	Excluded	Excluded	Excluded
483	TRACHEOSTOMY EXCEPT FOR FACE,MOUTH & NECK DIAGNOSES	Excluded	Excluded	Excluded
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.7762	35	10.6
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	3.1562	33	8.3

486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8882	33	8.8
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0229	30	5.9
488	HIV W EXTENSIVE O.R. PROCEDURE	4.5078	38	12.1
489	HIV W MAJOR RELATED CONDITION	1.8009	31	6.7
490	HIV W OR W/O OTHER RELATED CONDITION	0.9952	28	4.2
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.6579	19	3.3
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	4.6393	35	11.9
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7561	28	4.1
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	0.94	15	1.8
495	LUNG TRANSPLANT	Excluded	Excluded	Excluded
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION Note – For admissions on or after * 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	5.5214		9.2
497	SPINAL FUSION W CC Note – For admissions on or after * 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	2.7692		5.3
498	SPINAL FUSION W/O CC Note – For admissions on or after * 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	1.6171		3.1
499	BACK & NECK PROCS EXCEPT SPINAL FUSION W CC	1.4827		4.1

	Note – For admissions on or after *, 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).			
500	BACK & NECK PROCS EXCEPT SPINAL FUSION W/O CC Note – For admissions on or after *, 2000, the cost of implantable hardware and instrumentation for this DRG is excluded from the DRG computed fee and reimbursed separately pursuant to § 9792.1(c)(9).	0.9708		2.6
501	KNEE PROC W PDX OF INFECTION W CC	2.566		8.7
502	KNEE PROC W PDX OF INFECTION W/O CC	1.6004		5.9
503	KNEE PROCEDURES W/O PDX OF INFECTION	1.238		3.4

*** An important note about the effective date of the proposed amendments to DRGs 496 through 500, inclusive:**

As stated in the Notice of Proposed Rulemaking, in order to have these regulations take effect as soon as possible, the Division will be asking the Office of Administrative Law for the regulations to have an effective date of “effective on filing with the Secretary of State.” The proposed regulations therefore have blank spaces where the effective date will be. The Office of Administrative Law will fill in the effective date as the date on which the regulations as adopted are filed with the Secretary of State.

**State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
P.O. Box 420603
San Francisco, CA 94142**

**NOTICE OF ERRATA IN AND ADDITION OF DATA TO INPATIENT
HOSPITAL FEE SCHEDULE INITIAL STATEMENT OF REASONS**

1. Error in Data Display Concerning the Proposed Cost Outlier Threshold:

We have identified three errors on page four of the July 28, 2000, Initial Statement of Reasons for the proposed amendments to the Inpatient Hospital Fee Schedule. The errors concern the analysis of the data from the Office of Statewide Health Planning and Development (OSHPD) and Blue Cross.

The OSHPD data error concerns the percentage of cases that would be excluded by a cost outlier threshold of total billed charges exceeding four times the individual hospital fee schedule maximum allowable reimbursement rate. The table incorrectly states that a cost outlier threshold of four would exclude 21.0% of the cases in the OSHPD database. A cost outlier threshold of four would actually exclude 12.1% of the cases in the OSHPD database.

The Blue Cross data errors concern the percentage of cases that would be excluded by a cost outlier threshold of total billed charges exceeding five and six times the individual hospital fee schedule maximum allowable reimbursement rate. The table incorrectly states that a cost outlier of five would exclude 13.0% of cases. A cost outlier threshold of five would actually exclude 13.5% of the cases in the Blue Cross database. The table also incorrectly states that a cost outlier of six would exclude 9.0% of cases. A cost outlier threshold of six would actually exclude 9.5% of the cases in the Blue Cross database. The attached replacement page contains the correct data.

2. Addition of Blue Cross Percentage of Excluded Charges Data:

In order to conform the data analysis for the Blue Cross data discussed in the ISOR, to the data analysis presented for the OSHPD data, the Division has calculated the percentage of charges that would be excluded by applying a cost outlier threshold of three, four, five or six times the individual hospital fee schedule maximum allowable reimbursement rate. This information was not provided in the July 28, 2000, Initial Statement of Reasons. The attached replacement page displays this additional data.

Please replace page four of the July 28, 2000, Initial Statement of Reasons you received with the enclosed replacement page four dated August 28, 2000.

We apologize for the inconvenience caused by this substitution.

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation**

INITIAL STATEMENT OF REASONS

Subject Matter of Proposed Amendments to Regulations: Workers' Compensation – Payments for Inpatient Hospital Services

The Administrative Director of the Division of Workers' Compensation proposes to amend Title 8 of the California Code of Regulations, Section 9792.1. Section 9792.1 concerns fees for inpatient hospital services in workers' compensation cases.

Hearing Dates:

Southern California:

**Date: Tuesday, September 26, 2000
Time: 10:00 a.m.
Place: Carmel Auditorium
State Office Bldg.
320 West 4th Street
Los Angeles, California 90013**

Northern California:

**Date: Thursday, September 28, 2000
Time: 10:00 a.m.
Place: Auditorium
Gov. Hiram Johnson State Office Bldg.
455 Golden Gate Avenue
San Francisco, California 94102**

AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:

The Inpatient Hospital Fee Schedule ("IHFS") component of the Official Medical Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code Section 11343(a)(1) and is therefore not subject to Article 5 of the Administrative Procedure Act (commencing at Government Code Section 11346.)

This rulemaking proceeding to amend the IHFS is being conducted under the Administrative Director's rulemaking power under Labor Code Sections 5307.1 and 5307.3. This regulatory proceeding is subject to the procedural requirements of Labor Code Sections 5307.1 and 5307.4.

This Initial Statement of Reasons, and the accompanying Notice of Rulemaking are being prepared to comply with the procedural requirements of Labor Code Section 5307.4 and for the convenience of the regulated public to assist the regulated public in analyzing and commenting on this non-APA rulemaking proceeding.

BACKGROUND TO REGULATORY PROCEEDING:

Labor Code Section 5307.1 requires the Administrative Director [AD] of the Division of Workers' Compensation [DWC] to "adopt and revise, no less frequently than biennially, an official medical fee schedule which shall establish reasonable maximum fees paid for medical services provided pursuant to

[Division 4 of the Labor Code]." The Official Medical Fee Schedule [OMFS] was last revised effective April 1, 1999.

One portion of the OMFS applies just to hospital inpatient services. The Inpatient Hospital Fee Schedule component of the OMFS establishes a maximum "global fee" for services made in connection with particular "diagnosis related groups" [DRGs]. DRGs are codes used to group related types of procedures for reimbursement purposes.)

The maximum global fee for a specific procedure at a specific facility is determined by multiplying 1.20 by the product of the health facility's composite factor, (a factor that is based on the unique cost and service differentials applicable to specific individual facilities), and the applicable DRG weight (or revised DRG weight if a revised weight has been adopted by the Administrative Director).

Admissions where the length of stay exceeds a set threshold are excluded from the application of the fee setting methodology described above. Such admissions are referred to as "outliers."

In 1997, Medicare dropped its use of length of stay outliers and shifted to a cost outlier methodology. Cost outliers are those cases where the total adjusted¹ billed charges for covered services, for a hospital discharge exceed the hospital's DRG determined payment rate plus a specific dollar amount (adjusted for geographic variance in costs) determined annually by the Secretary of Health and Human Services (HHS) and published in the Federal Register. For fiscal year 2000, the amount added to the prospective payment system rate to trigger outlier payments for all DRGs is \$14,050.² (See, 64 FR 41490, July 30 1999.)

The Administrative Director has learned from both the payor and provider communities that the continued use of length of stay outliers under California's Inpatient Hospital Fee Schedule is causing significant shortfalls in reimbursement for some sophisticated inpatient surgical procedures where the total costs of the admission greatly exceed the fee schedule's maximum allowable reimbursement without exceeding the length of stay outlier threshold. This situation may result in a threat to access to health care for seriously injured workers.

The Administrative Director has also learned from both the payor and provider communities that the DRG weights for the five spine related surgical DRGs specified below produce reimbursement levels under the fee schedule that are so low that some facilities are actively discouraging and in some cases even preventing surgeons from performing these procedures on an inpatient basis at their facilities. This may pose a threat to access to health care for seriously injured workers.

¹ Section 42 CFR 412.84(h) provides that the operating cost-to-charge ratio and the capital cost-to-charge ratio used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. The Health Care Financing Administration (HCFA) sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under § 412.8(b).

² \$12,827 for hospitals that have not yet entered the prospective payment system for capital related costs.

Recent technological advances in orthopedic spine-related surgery often utilize instrumentation and hardware such as pedicle screws, titanium screws and plates, interbody fixation cages and implantable bone growth stimulators which are extremely expensive.

The California Medical Association reports that hardware costs can run anywhere from approximately \$1,500 to \$14,000 per surgery. The AD has been informed that the reimbursement levels under the current spine related DRG groups often do not cover even the implanted hardware costs for some of these procedures, thereby forcing hospitals to choose between losing money on these procedures or refusing to allow these procedures to be performed in their facilities.

(1) Proposed Section - 9792.1(c)(8) - Excluding Cost Outlier Cases from the Fee Schedule

Problem Addressed:

Admissions where the length of stay exceeds a set threshold are excluded from the application of the fee setting methodology described above. Such admissions are referred to as “outliers.”

The Administrative Director has learned from both the payor and provider communities that the continued use of length of stay outliers under California’s Inpatient Hospital Fee Schedule is causing significant shortfalls in reimbursement where the total costs of the admission greatly exceed the fee schedule’s maximum allowable reimbursement without exceeding the length of stay outlier threshold. This situation may result in a threat to access to health care for seriously injured workers.

Specific Purpose of Adoption of Section 9792.1(c)(8):

The proposed adoption of Section 9792.1(c)(8) will add a cost outlier methodology alongside the length of stay outlier methodology already in place. The cost outlier threshold, effective where the admission occurs on or after the effective date of the regulations, will be triggered where the total billed charges for the admission, excluding non-medical charges such as television and telephone charges, exceed five (5) times the DRG computed reimbursement. This approach was chosen to avoid the complex hospital-by-hospital adjustments that are required under the Medicare cost outlier methodology.

The effect of adopting a cost outlier methodology will be to allow the provider to be reimbursed outside of the fee schedule for reasonable and necessary charges for outlier cases. This will reduce the potential for severe underpayments where an admission proves to be exceptionally costly although not exceptionally lengthy.

Factual Basis That Adoption is Necessary

The current inpatient hospital fee schedule relies on a length of stay or “day outlier” methodology for exempting exceedingly high cost cases from the fee schedule. The “day outlier” method was selected because it was in use by Medicare at the time the fee schedule was originally developed. However, Medicare has subsequently moved to a cost outlier methodology. The cost outlier methodology addresses a key problem with the day outlier approach: some cases require very intensive and costly care, the costs of which far exceed the DRG reimbursement amount, even if the length of stay is not significantly different than the average length of stay for that particular DRG.

As indicated in the documents relied upon, as identified and summarized below, many hospitals and even some payors have indicated to the Division that there are a significant number of workers' compensation hospitalizations in which the costs to hospitals far exceed the fee schedule reimbursement, even when the length of stay is not very long. DWC has received anecdotal evidence that some hospitals may be refusing to admit some complex workers' compensation cases because of concerns about losses on these very costly outlier cases.

Although the inpatient hospital fee schedule is generally modeled on the Medicare model, the Division determined that adopting the Medicare cost outlier methodology would not be feasible. Medicare uses a very complicated cost outlier formula that relies on hospital-specific calculations of cost-to-charge ratios. These calculations use highly individualized and hospital specific factors that are applied to each hospital's billings by Medicare's contracted intermediaries. There is no parallel intermediary structure like that of Medicare's within California's workers' compensation system.

The level of the proposed cost outlier threshold was determined by evaluating the application of various outlier thresholds on a database derived from a database maintained by the Office of Statewide Health Planning and Development (OSHPD), a department within the State Health and Human Services Agency. The database includes information on discharges and average length of stay by type of care and county, DRG, expected source of payment, patient demographics, and other data. This database is called the "Patient Discharge Data by Calendar Year" database. The data obtained was for calendar year 1998, and is the most current data available from OSHPD.

The OSHPD data was analyzed to determine what proportion of workers' compensation hospitalizations would be excluded from the fee schedule by applying an outlier threshold of total billed charges exceeding three, four, five or six times the individual hospital fee schedule maximum allowable reimbursement rate. The results of this analysis were as follows:

Charge to fee schedule maximum reimbursement ratio:	Percentage of cases: Percentage of charges:	
3	24.0%	46.9%
4	21.0%	30.9%
5	6.6%	21.1%
6	4.0%	15.5%

An additional data sample was also analyzed. The second data sample was provided by Blue Cross, a statewide Preferred Provider Organization (PPO) with a substantial portion of the overall market. The sample consisted of 1000 hospital admissions occurring on or after April 1, 1999. The percentage of hospitalizations with charges 3, 4, 5, and 6 times the DWC fee schedule reimbursement was also calculated for the Blue Cross data, resulting in the following data:

Charge to DRG ratio:	Percentage of 1999 workers' compensation hospitalizations (from 1000 case sample) that exceed the ratio:
3	34.9%
4	21.6%
5	13.0%
6	9.0%

As indicated in the documents relied upon, as identified and summarized below, many hospitals and even some payors have indicated to the Division that there are a significant number of workers' compensation hospitalizations in which the costs to hospitals far exceed the fee schedule reimbursement, even when the length of stay is not very long. DWC has received anecdotal evidence that some hospitals may be refusing to admit some complex workers' compensation cases because of concerns about losses on these very costly outlier cases.

Although the inpatient hospital fee schedule is generally modeled on the Medicare model, the Division determined that adopting the Medicare cost outlier methodology would not be feasible. Medicare uses a very complicated cost outlier formula that relies on hospital-specific calculations of cost-to-charge ratios. These calculations use highly individualized and hospital specific factors that are applied to each hospital's billings by Medicare's contracted intermediaries. There is no parallel intermediary structure like that of Medicare's within California's workers' compensation system.

The level of the proposed cost outlier threshold was determined by evaluating the application of various outlier thresholds on a database derived from a database maintained by the Office of Statewide Health Planning and Development (OSHPD), a department within the State Health and Human Services Agency. The database includes information on discharges and average length of stay by type of care and county, DRG, expected source of payment, patient demographics, and other data. This database is called the "Patient Discharge Data by Calendar Year" database. The data obtained was for calendar year 1998, and is the most current data available from OSHPD.

The OSHPD data was analyzed to determine what proportion of workers' compensation hospitalizations would be excluded from the fee schedule by applying an outlier threshold of total billed charges exceeding three, four, five or six times the individual hospital fee schedule maximum allowable reimbursement rate. The results of this analysis were as follows:

Charge to fee schedule maximum reimbursement ratio:	OSHPD Data	
	<u>Percentage of cases</u>	<u>Percentage of charges</u>
3	24.0%	46.9%
4	12.1%	30.9%
5	6.6%	21.1%
6	4.0%	15.5%

An additional data sample was also analyzed. The second data sample was provided by Blue Cross, a statewide Preferred Provider Organization (PPO) with a substantial portion of the overall market. The sample consisted of 1000 hospital admissions occurring on or after April 1, 1999. The percentage of hospitalizations with charges 3, 4, 5, and 6 times the DWC fee schedule reimbursement was also calculated for the Blue Cross data, resulting in the following data:

Charge to fee schedule maximum reimbursement ratio:	1999 Blue Cross WC hospitalizations (1,000 case sample)	
	<u>Percentage of cases</u>	<u>Percentage of charges</u>
3	34.9%	59.0%
4	21.6%	42.1%
5	13.5%	31.8%
6	9.5%	24.7%

In light of the OSHPD and Blue Cross data, the Division determined that setting the cost outlier threshold at five times the total billed charges, excluding non-medical charges such as television and telephone charges, would be appropriate because exemption of a larger number of hospitalizations from the fee schedule seemed likely to raise workers' compensation costs excessively, while a higher threshold would not remedy the under-reimbursement that currently threatens access to care for seriously injured workers.

A detailed memorandum, dated July 25, 2000, from Linda Rudolph, DWC Medical Director, describing the database analyses described above is contained in the rulemaking file as a document relied upon in this rulemaking.

Small Business Impact

This regulation will not have a significant effect on small business.

Specific Technologies or Equipment

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

No alternative was considered which would be either more effective than or equally as effective as and less burdensome than the proposed regulations.

In 1997, Medicare dropped its use of length of stay outliers and shifted to a cost outlier methodology. Cost outliers are those cases where the total adjusted³ billed charges for covered services, for a hospital discharge exceed the hospital's DRG determined payment rate plus a specific dollar amount (adjusted for geographic variance in costs) determined annually by the Secretary of HHS and published in the Federal Register. For fiscal year 2000, the amount added to the prospective payment system rate to trigger outlier payments for all DRGs is \$14,050.⁴ (See, 64 FR 41490, July 30 1999.)

Medicare outlier payments are provided for in Title 42 CFR Sections 412.80 through 412.86. Section 412.80 provides the general rules for outlier payments and Section 412.84 provides the specific methodology for calculating cost outlier payments.

³ Section 42 CFR 412.84(h) provides that the operating cost-to-charge ratio and the capital cost-to-charge ratio used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. HCFA sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under § 412.8(b).

⁴ \$12,827 for hospitals that have not yet entered the prospective payment system for capital related costs.

Essentially, the Medicare cost outlier reimbursement methodology provides that the amount of the additional reimbursement in outlier cases is 80% of the difference between the hospital's adjusted billed charges for the discharge and the threshold amount.

Although the inpatient hospital fee schedule is generally modeled on the Medicare model, the Division determined that adopting the Medicare cost outlier methodology would not be feasible. Medicare uses a very complicated cost outlier formula that relies on hospital-specific calculations of cost-to-charge ratios. These calculations use highly individualized and hospital specific factors that are applied to each hospital's billings by Medicare's contracted intermediaries. There is no parallel intermediary structure like that of Medicare's within California's workers' compensation system.

An alternative approach would be to adopt a dollar threshold cost outlier. For example, the State of Texas has adopted a dollar threshold cost outlier of \$40,000. Cases in which hospital charges exceed \$40,000 are excluded from the regular hospital fee schedule, and are paid at a percentage of total charges. While this approach is administratively simple, it fails to take into account significant individual differences in hospitals' expenses, and likewise does not account for significant inter-hospital differences related to population and case mixes. Labor Code Section 5307.1(a)(1) requires DWC to take differences in cost and service differentials into account in the development of the fee schedule. The fee schedule incorporates HCFA's individual hospital expense factors into the fee schedule mechanism. Thus, each hospital receives a slightly different reimbursement for the same DRG. A single dollar-threshold cost outlier would mean that these differences would not be taken into account in the application of the cost outlier, in contrast to the rest of the fee schedule.

(2) Proposed Section - 9792.1(c)(9) - Excluding Surgically Implantable Hardware and Instrumentation from the Fee Schedule's Maximum Computed Reimbursement

Problem Addressed:

The Administrative Director has learned that the costs of the implantable hardware and instrumentation such as titanium cages used in spinal surgeries in DRGs 496 through 500 often exceed the total maximum global fee computed under the fee schedule.

Because of this disparity between procedure costs and fee schedule reimbursement levels, the Administrative Director has been informed that some hospitals are refusing to allow complex spinal surgeries to be scheduled in their facilities.

The DRGs in question are as follows:

- DRG 496 Combined Anterior/Posterior Spinal Fusion
- DRG 497 Spinal Fusion with CC ⁵
- DRG 498 Spinal Fusion without CC
- DRG 499 Back and Neck Procedures except Spinal Fusion with CC
- DRG 500 Back and Neck Procedures except Spinal Fusion without CC

Specific Purpose of Adoption of Section 9792.1(c)(9):

⁵ Complicating Condition(s).

The proposed adoption of Section 9792.1(c)(9) will exclude the cost of implantable hardware and instrumentation for spinal related surgeries, DRGs 496 through 500, from the global DRG computed fee where the admission occurs on or after the effective date of the regulations.

The cost of implantable hardware and/or instrumentation for DRGs 496 through 500, where the admission occurs on or after the effective date of the regulations, will be separately reimbursed at documented cost, plus any sales tax and/or shipping and handling charges actually paid, plus 10% of documented cost.

The proposed regulation will allow separate reimbursement in addition to the DRG computed fee for both the documented costs of the instrumentation and hardware for these specified DRGs and a portion of the facility's overhead costs in acquiring the instrumentation and hardware.

Factual Basis That Adoption is Necessary

As indicated in the documents relied upon, as identified and summarized below, the Division has received numerous complaints that the reimbursement levels for DRGs 469 through 500 are inadequate at least in part due to the expenses incurred by hospitals in procuring the hardware or instrumentation that is used in some spinal surgery procedures. The Division has also reviewed information provided by hospitals and payors that suggests that total hospital charges for these DRGs are, in fact, substantially lower than the OMFS reimbursement rates.

With respect to the costs of instrumentation and hardware, for example, the titanium cages used in some spinal fusion procedures are very expensive. The Division has reviewed data provided by hospitals and payors that suggests that total hospital costs for instrumentation and hardware alone for these DRGs are substantially higher in some cases than the total maximum global reimbursement rate for the entire hospitalization.

The Division has received information that the current reimbursement levels have led some facilities to refuse to allow these procedures to be performed, threatening injured workers' access to these procedures.

Although the Division has become convinced that it is necessary to allow separate reimbursement for instrumentation and hardware for the specified DRGs, the Division also feels that in order to avoid costly and time consuming billing disputes, it is also necessary to regulate the maximum allowable additional reimbursement for these items.

Small Business Impact

This regulation will not have a significant effect on small business.

Specific Technologies or Equipment

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

No alternative was considered which would be either more effective than or equally as effective as and less burdensome than the proposed regulations.

The Division considered completely exempting procedures DRGs 469 through 500 from the fee schedule but rejected this approach as such an approach would interfere with the Legislature's expressed intention that the fee schedule serve a cost containment purpose. Excluding DRGs 469 through 500 from the fee schedule would exclude a large percentage of workers' compensation admissions.

(3) Proposed Section - 9792.1 Appendix B – Clarifying Amendments to Heading and Description Sections

Problem Addressed:

Appendix B to Section 9792.1 sets forth the descriptions of the procedure covered by each DRG, the DRG weight, the length of stay outlier threshold and the geometric mean length of stay for all DRGs in the inpatient hospital fee schedule. The addition of a cost outlier will create a need to clarify that the outlier thresholds in Appendix B only refer to the length of stay outlier.

Specific Purpose of Amendments to Appendix B to Section 9792.1:

The heading section to Appendix B to Section 9792.1 is being amended to clarify that the outlier thresholds provided in Appendix B are length of stay outliers and to add a cross-reference to direct the regulated public to Section 9792.1(c)(8) that provides for cost outliers.

Notes are also being added to the descriptions for DRGs 496 through 500 to clarify that the costs of implantable hardware and instrumentation are excluded from the DRG-computed global fee and instead reimbursed separately pursuant to § 9792.1(c)(9).

Factual Basis That Amendment is Necessary

Currently, there is only one type of threshold, a length of stay threshold. Upon adding a second type of outlier, it would improve the clarity of the regulation for the regulated public to modify the heading as proposed.

Small Business Impact

This regulation will not have a significant effect on small business.

Specific Technologies or Equipment

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

In adopting these regulations, the Administrative Director must determine that no alternative considered by the agency would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed action.

Materials Relied Upon in this Rulemaking:

The Division has relied upon the following documents and other information contained in the rulemaking file in proposing the regulations:

- Memo dated July 25, 2000, to rulemaking file, from Linda Rudolph. Memo concerns the Division's analysis of various cost outlier thresholds applied to two data samples of inpatient workers' compensation admissions.
- Letter dated July 21, 2000, to Richard Gannon, Administrative Director, from Arthur L. Johnson, Esq., of Butts & Johnson. Letter is from an applicant's attorney and concerns a case in which an injured worker was actually discharged after being admitted to the hospital for spinal surgery when the hospital was unable to negotiate a higher reimbursement level with the insurer than would have been permitted under the fee schedule. The letter alleges that the insurer advised the attorney that his client should change surgeons in order to allow he to be treated at a facility that is willing to accept reimbursement under the fee schedule.
- Letter dated May 17, 2000, to Stephen Smith, Director of Industrial Relation, from Michael D. Drobot, Pacific Hospital of Long Beach.

Letter alleges that inadequate reimbursements for spinal related DRGs under current inpatient hospital fee schedule have led to many facilities refusing to provide these surgeries to injured workers. The cost drivers for these procedures are implantable hardware and instrumentation, longer operating room times, intensive care unit recovery times and inpatient hospital or rehabilitation unit stays.

Letter demands:

- immediate regulatory action to exclude implantable hardware costs from DRG computed fee,
- a pronouncement that the costs of instrumentation and other hospital costs for DRGs 496 – 500 constitute “extraordinary circumstances” under Labor Code § 5307(b) so that instrumentation costs may be separately billed and reimbursed in addition to the DRG computed fee.
- E-mail dated May 9, 2000, to Richard Gannon, Administrative Director, from Abdul Kasir, Executive Director of Managed Care – Tenet Health System.

E-mail requests immediate action to resolve multi-million dollar effects of inadequate reimbursement for DRGs 496 – 500.

- Letter dated May 1, 2000, to Richard Gannon, Administrative Director, from Michael D. Drobot, Pacific Hospital of Long Beach.

Letter requests immediate issuance of a policy statement that the costs of instrumentation for DRGs 496 – 500 constitute “extraordinary circumstances” under Labor Code § 5307(b) and should be separately reimbursed in addition to the DRG computed fee.

- Letter dated April 4, 2000, to Richard Gannon, Administrative Director, from Michael D. Drobot, Pacific Hospital of Long Beach.

Letter provides documentation in support of Pacific Hospital's allegation that costs of implantable hardware required for DRGs 496 – 500 will result in annual losses of approximately \$2.8 million.

Letter states that without relief, hospitals will return to cheaper but less effective surgical procedures to operate within DRG reimbursement levels. Letter states that this will result in a negative impact on patient recovery rates and increased disability costs to employers.

- Letter dated March 31, 2000, to Richard Gannon, Administrative Director, from Randall E. Seago, M.D., of Los Gatos Orthopedic Associates.

Letter states that reimbursement is completely inadequate under current inpatient hospital fee schedule for spinal surgeries requiring complex instrumentation procedures. Current fees were based on old less costly surgical technique of fusion that required much less operating room time, blood loss, post operative care and instrumentation. Letter asserts that while cheaper, old techniques had far greater rate of failures. Letter states that new procedures require greater expenditure of resources for pain control, blood replacement, fluid management, postoperative care and rehabilitation, but result in more surgeries that are successful.

Letter requests immediate action to revise the inpatient hospital fee schedule in order to allow injured workers access to necessary care.

- Letter dated March 30, 2000, to Richard Gannon, Administrative Director, from John J. Lettice, M.D., and Thomas A. Kula, M.D., spinal surgeons at Community Hospital of Los Gatos.

Letter states that inadequacy of inpatient hospital fee schedule reimbursement levels for spinal surgeries cause losses of over \$100,000.00 per case for Community Hospital of Los Gatos.

Letter states that spinal procedures are extremely expensive and time consuming involving state of the art instrumentation and at least one night's stay in the Intensive Care Unit for monitoring and care. Patients then typically spend 5 – 6 days in the hospital and require extensive nursing care, physical and occupational therapy and discharge planning care.

Letter requests immediate revision to the inpatient hospital fee schedule to allow negotiated rates for spinal instrumentation surgeries on either a contractual or case-by-case basis.

- Letter dated March 24, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Barbara Jones, California Healthcare Association.

Letter provides analysis of the effects of setting cost outlier thresholds at 2, 2.5 and 3 times the fee produced under the inpatient hospital fee schedule. Analysis is based on data reported by Association members to the Office of Statewide Health Planning and Development for over 26,000 inpatient workers' compensation claims.

Letter states that setting the outlier at the following levels will exclude the following percentages of cases across all DRGs:

Fee Schedule Multiplier	Number of Outlier Occurrences	Percentage of Cases Excluded
2	16,516	62%
2.5	11,135	42%
3	7,498	28%

The letter notes that the percentage of outliers shown reflects only the number of occurrences and does not take into account dollar amounts.

- Letter dated March 16, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Aynah Askanas, Rheinsch Medical Management.

Letter states that hospital administrators are complaining that they are experiencing severe monetary losses because of the inadequate reimbursement levels for DRGs 496 – 500 and are considering prohibiting spinal instrumentation surgeries in their facilities.

Letter also states that spine surgeons are informing them that some hospitals are already discouraging, postponing or even refusing medically necessary spinal instrumentation surgeries for workers' compensation patients due to inadequate reimbursement levels.

Letter requests immediate regulatory action to address these issues, and asks that regulations be made retroactive to April 1999 (effective date of the inpatient hospital fee schedule).

- Letter dated March 9, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Jeffrey D. Coe, M.D., spine surgeon, Los Gatos.

Letter states that he has had to postpone surgeries until the hospital could negotiate what it considered reasonable reimbursement arrangements for the procedures.

Letter requests immediate action to revise the inpatient hospital fee schedule to address these issues, and asks that revisions be made retroactive to April 1, 1999, the effective date of the inpatient hospital fee schedule.

- Letter dated February 29, 2000, to Richard Gannon, Administrative Director, from Susan Haag, Community Care Network. Letter provides inpatient bill data to document fiscal impact of low DRGs on hospitals and states that some hospitals are refusing to treat inpatient workers' compensation cases due to low reimbursement rates.

Letter requests adoption of a cost outlier provision, especially for DRGs 496 – 500. Letter also expresses concern that disputes over reimbursement will appear before the WCAB thereby increasing administrative costs for DWC, payors and providers.

- Letter dated February 24, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Barbara Jones, California Healthcare Association.

Letter provides fiscal data on both dollar loss and percentage of charge lost basis to document impact of low DRGs on hospitals, particularly for DRGs 496 – 500.

Letter requests:

- increase in DRG levels,
 - adoption of cost outlier / stop loss provisions,
 - expansion of “extraordinary circumstances” exception to the inpatient hospital fee schedule to apply to cases where cost of services exceed the inpatient hospital fee schedule reimbursement,
 - guarantee that reimbursements under the inpatient hospital fee schedule not be less than the facility charges times the Medicare cost to charge ratio to determine payment of costs,
 - issuance of emergency regulations excluding spinal surgeries and other low reimbursement DRGs from the inpatient hospital fee schedule,
 - allowing payment of costs plus an overhead margin,
 - acceleration in the schedule for updating the inpatient hospital fee schedule. (The next regularly scheduled revision due to take effect April 1, 2001.)
- Letter dated February 22, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Edgar Dawson, M.D., Clinical Professor of Orthopedic Surgery at UCLA School of Medicine and Clinical Director of the UCLA Comprehensive Spine Center.

Letter concerns fiscal impact of low spine related DRGs on hospitals and states that spinal surgeries that require implants are being discouraged because the hospitals are not being reimbursed for the costs of the implantable hardware. Letter states that these surgeries reduce hospital length of stay and facilitate earlier and more successful return of patient to work.

Letter states that continuing losses for spinal implantation surgeries may result in a reduction in quality of care to injured workers by a return to less successful fusion procedures or refusal by some facilities to provide inpatient care in workers’ compensation cases.

Letter states that using Medicare benchmarking for spinal procedures is inappropriate because very few spinal surgeries are performed on Medicare’s patient population so hospitals with high volume of Medicare patients make up for shortfalls in spinal surgery costs through averaging out these procedures with higher paid charges for other admissions.

Letter requests immediate issuance of emergency regulations, retroactive to April 1, 1999, the effective date of the inpatient hospital fee schedule, excluding spine instrumentation from the inpatient hospital fee schedule and allowing payment for DRGs 496 – 500 on a negotiated basis.

- Letter dated February 18, 2000, to Richard Gannon, Administrative Director, from Ryan Smith, Community Hospital of Los Gatos.

Letter states that inpatient hospital fee schedule is seriously flawed as it does not contain any provisions for outlier reimbursement for extremely costly procedures for DRGs 496 – 500.

Letter states that these cases require more operating room time than other cases and a 3-4 day stay in the Intensive Care Unit.

Letter states that due to extent of per case fiscal losses, hospital has had ask surgeons to postpone procedures until an acceptable reimbursement rate could be negotiated or the payor agreed to reimbursement on a contractual rate basis.

Letter states that since the inpatient hospital fee schedule went into effect on April 1, 1999, surgeons at their hospital have performed approximately 202 cases in DRGs 496 – 500 with non-reimbursed costs in excess of \$2.5 million.

Letter states that continuing losses may force this facility to refuse to treat inpatient workers' compensation cases.

Letter requests exemption of DRGs 496 – 500 from the inpatient hospital fee schedule and allowing payment for DRGs 496 – 500 on a negotiated reimbursement basis.

- Letter dated February 15, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Ken Steele of Catholic Healthcare West.

Letter identifies 20 DRGs with most serious negative financial impact on hospitals – over \$4.3 million and requests exclusion of these DRGs from the inpatient hospital fee schedule so that hospitals could negotiate market competitive rates for these procedures.

- Letter dated February 11, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Mariano Catbagan, Community Hospital of the Monterey Peninsula.

Letter concerns fiscal impact of low spine related DRGs on their hospital and states that continuing losses may result in an inability to provide instrumented spine procedures for injured workers.

Letter states that the inpatient hospital fee schedule severely under-reimburses hospitals for DRGs 496 – 500.

Letter requests regulations addressing reimbursement issues be retroactive to April 1, 1999, the effective date of the inpatient hospital fee schedule, and allow payment for DRGs 496 – 500 on a negotiated basis.

- Letter dated February 11, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Jim Canedo, Pacific Hospital of Long Beach.

Letter states that they estimate their annual unreimbursed costs for implantable spinal hardware to be \$159, 000 and for DRGs 496 – 500 to be \$2,518,000.00.

Letter requests adopting Medicare cost outlier methodology and increasing certain DRG ratios to reimburse implant costs.

Letter requests emergency regulations allowing separate reimbursement for spinal implant costs on a negotiated basis outside the inpatient hospital fee schedule and that the regulations be made retroactive to April 1, 1999, the effective date of the inpatient hospital fee schedule.

- Letter dated January 28, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Rea Crane, California Workers' Compensation Institute.

Letter states that based on data for slightly over 1300 inpatient payments from five carriers, percentage reductions from billed charges to fee schedule payments range from 62% to 73% across various DRGs.

- Letter dated January 21, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Timothy Hoops, Vice President of Workers' Compensation Managed Care Services, Blue Cross.

Letter provides listing of 17 DRGs where application of the inpatient hospital fee schedule resulted in more than a 50% reduction in the billed charges.

Letter states that they are aware of hospitals not scheduling surgeries or scheduling surgeries as outpatient procedures due to low levels of inpatient hospital fee schedule reimbursement.

Letter recommends shifting from length of stay outliers to a \$40,000 cost outlier threshold. Recommendation is based on analysis of Blue Cross's claims database and negotiated PPO stop loss provisions.

- Letter dated January 20, 2000, to Linda Rudolph, M.D., DWC Medical Director, from Sue Galanti, Orthopedic Hospital.

Letter states that on two inpatient spine surgery cases their hospital lost an estimated \$20,700 in revenue comparing the inpatient hospital fee schedule reimbursement to the average contract rate.

Letter speculates that inpatient hospital fee schedule length of stay outlier is set too high for a relatively young and healthy patient population under workers' compensation as opposed to Medicare's patient population. Letter also suggests shifting from length of stay to cost outlier methodology since most workers' compensation covered inpatients are surgical patients.

- Letter dated November 18, 1999, to Richard Gannon, Administrative Director, from Aynah Askanas, California Medical Association.

Letter states that costs of implantable spinal hardware ranges from approximately \$1,500 to \$14,000 per surgery and that unlike reimbursement prior to the inpatient hospital fee schedule, the inpatient hospital fee schedule does not allow separate reimbursement for this hardware.

Letter states that while spinal surgery patients generally do not exceed the average length of stay outlier threshold, such admissions would trigger a cost outlier payment methodology.

Letter states that from a hospital's viewpoint, the only acceptable alternative to adopting a cost outlier methodology would be to allow negotiated reimbursement on a case-by-case basis.

Letter suggests:

- allowing separate and additional reimbursement for documented costs of spinal surgery implants and instrumentation as “exceptional circumstances” requiring payment over and above the inpatient hospital fee schedule DRG computed fee,
 - declaring that a cost, plus a specific percentage, reimbursement methodology for instrumentation is allowable under Labor Code Section 4614(c) as it would provide overall savings in workers’ compensation cases, or,
 - adopting a cost outlier methodology.
- Letter dated November 2, 1999, to Richard Gannon, Administrative Director, from Barbara Jones, California Healthcare Association.

Letter states that the level of reimbursement for back-related surgeries under the inpatient hospital fee schedule causes hospitals per procedure losses of \$10,000 to \$40,000.

One facility claims that reimbursement for such cases has been reduced by 49%.

Letter recommends shifting from length of stay outliers to a cost outlier methodology and updating the inpatient hospital fee schedule to 1999 DRGs to follow Medicare’s fee schedule methodology. As an alternative, letter proposes unbundling some services from the DRGs and allowing separate reimbursement for those items.

- Letter dated September 30, 1999, to Richard Gannon, Administrative Director, from Ed Woodward, California Workers’ Compensation Institute.

Letter states that the inpatient hospital fee schedule leads to extremely large reductions in billed charges, up to 90% in some cases. Letter states that this could lead to impairment of injured workers’ access to treatment.

Letter states that carriers are bound to pay in accordance with the inpatient hospital fee schedule or face policyholder anger and possible litigation.

Letter recommends prompt re-evaluation of the inpatient hospital fee schedule and correction of deficiencies.

- Letter dated September 29, 1999, to Richard Gannon, Administrative Director, from George Lenzi, Sutter Davis Hospital.

Letter states that the inpatient hospital fee schedule severely under-reimburses surgical spinal care. In one case, the billed charges for the implantable hardware alone exceeded the DRG computed global fee. The hospital was therefore was not compensated for the operating room staff, supplies, anesthesia, two days of inpatient stay, physical therapy, pain medications and other charges.

The letter recommends adopting a new inpatient hospital fee schedule methodology that would take implant costs into account.

Availability of Rulemaking File for Public Inspection

As set forth in the Notice of Proposed Rulemaking, any interested person may inspect a copy of or direct questions about the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file.

The rulemaking file will be available for inspection at the Division of Workers' Compensation, 455 Golden Gate Avenue, Ninth Floor, San Francisco, CA 94102, between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

Copies of the text of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person for these requests is:

Ms. Guia Carreon
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The telephone number of the contact person is (415) 703-4600.

Business Impact

The Administrative Director finds that adoption of these regulations may have a significant economic impact on businesses, both adverse and beneficial.

To the extent that private persons and entities are self-insured employers, who must themselves directly reimburse medical providers, the cost impact is the same as on self-insured governmental agencies, as discussed in the section entitled "Costs or Savings to Local Agencies, School Districts and State Agencies."

Workers' compensation insurers will also be subject to the costs discussed above.

Hospitals receiving payment for services under the IHFS will, in aggregate, enjoy a beneficial economic impact to the same extent that payers will suffer an adverse impact.

A detailed fiscal analysis, dated July 28, 2000, of the fiscal impact on hospitals and payors of the proposed regulations has been prepared by the Administrative Director and is included in the rulemaking file.

Specific Technologies or Equipment

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives

In adopting these regulations, the Administrative Director must determine that no alternative considered by the agency would be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposed action.

Statement Concerning the Administrative Director's Determination of the Economic Impact of the Proposed Regulations on Business:

Pursuant to Government Code Section 11346.2(b)(5) the Administrative Director hereby sets forth the "facts, evidence, documents, testimony, or other evidence upon which the agency relies to support a finding that the action will not have a significant adverse economic impact on business." As stated in the Notice of Proposed Rulemaking, the Administrative Director finds that adoption of the proposed regulations will not have a significant adverse economic impact on businesses, nor will they have a significant impact on the ability of California businesses to compete with businesses in other states.

By allowing certain costs to be reimbursed that were not previously allowed, the proposed regulations represent only a shift between two participants, those of payors and providers. There would therefore be only minimal, if any, net economic change.

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